In such an effort the officers of the medical and pharmaceutical associations would be only too glad to render advisory and other aid. If the ordinance is permitted to remain on the statute books, in dead letter or other form, a dose of "pitiless publicity" might be of benefit to the community. The ray of hope in this matter, and also as regards sanity in legislation, may be in a referendum which, at the time these lines are written, rumor states, may be invoked. If such a referendum is presented, the ordinance would lie over until the local or state elections in the fall of 1930. In the meantime, the honorable city fathers of Los Angeles would have an opportunity to give their attention to a host of vastly more important civic problems which are pending on the files of the city council.

TELEPHONED NARCOTIC PRESCRIPTIONS

Changes in the State Narcotic Laws.—Under the new California anti-narcotic law, which was passed by the legislature at its last session and which became effective August 14, 1929, the control of the sale and dispensation of narcotics in the State of California was transferred to the new Narcotic Division of the Department of Penology of the State of California. Senator F. H. Benson is the director of the division.

Both Federal and California laws state that the only legal authority upon which a pharmacist may dispense narcotics is a prescription which contains, *in the prescribing physician's own handwriting,* the name and address of the patient, the actual date upon which the prescription was signed and the physician's signature. The Federal law, which is written into the California law, has been interpreted to mean that dispensation of a narcotic by a pharmacist upon the telephoned instruction of a physician is in direct violation of the law, no matter whether the physician himself signs a prescription ten minutes after such dispensation has been completed.

In the past, the authorities have been somewhat lenient in the enforcement of this clause in the law and, as is usual, advantage has been taken by those who used this lenience to indulge their laziness, carelessness or indifference, and did not confine the use of this official tolerance to times of real emergency.

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Narcotic Laws Will be Enforced.—As a result, endeavoring to correct the present state of affairs, the Narcotic Division has announced that it will not countenance this violation of the law and has already caused the arrest of a licensed pharmacist who dispensed a narcotic upon a prescription telephoned to him by a duly licensed and registered physician.

The incident cited above indicates the present temper of the Narcotic Division, and it is well for us to remember when we are tempted to phone a druggist and ask him to deliver a narcotic to a patient that we are asking him to break the law and place himself in jeopardy in order to save ourselves some effort. We cannot blame him or be resentful when he refuses our request. Coincidentally, the physician is also breaking the law in making the request and, at the will of the Narcotic Division, may be arrested also.

Committees from the various retail druggists' associations and some of the component county societies are working together in this matter, endeavoring to place the situation, as it exists, before the members of their respective organizations. Further consideration of the situation will be had by the officers of the California Medical Association and further information will be contained in future issues of CALIFORNIA AND WESTERN MEDICINE, or letters sent to you by the Council or Executive Committee.

In the meantime do not violate the law or ask others to abet you in its violation.

SOME TRENDS IN HOSPITAL TREATMENT, IN RELATION TO THE "HIGH COST OF MEDICAL CARE"

Reasons Why More People Do Not Go to Hospitals.—In the last few years much has been said in medical meetings on the advisability of teaching the public how advantageous it would be if the members of the public who were sick or injured would more often go to hospitals. The benefits of the more skilled nursing care and the better environment of the hospital service have been cited as good reasons for giving such advice.

Incidentally it has also been quietly acknowledged in professional circles that the physician or surgeon who has a very large practice is able to do much more work and with far less wear and strain to himself when his patients are housed in hospitals than when he is obliged to visit a corresponding group of patients living in different parts of a city and each with a somewhat different social and family environment. The younger or less busy physician also very often finds personal satisfaction in his hospital work, because even though he may have fewer patients the hospital makes for pleasant contacts with colleagues whom he meets as rounds are made.

However, the major argument for hospital care is that the patient as a rule there receives much better treatment than in the home, and that increased hospital cost is only relative in that the patient through hospital care is able to return to his home and his work at an earlier date than would be possible under treatment at home. From the standpoint of cold-blooded scientific medicine, the argument just stated is not without considerable merit. If all the patients sent to the hospitals for this better care had the means enabling them to pay for the extra cost of the same, there seemingly could be no objection to this plan of general or universal hospital treatment.

Therein, however, lies the rub, or the bone of contention. For the great majority of patients do not have the financial resources which permit them to enter a hospital, without attendant worry or disaster over the overhead costs incident to such hospital regimen. And because of this fact, the theory of the better care in hospitals, and of sending more sick and injured people to the hospitals, like other theories that are not based on con-

ditions as they actually exist, loses much of its force.

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Some Limitations of the Hospital Propaganda. Since many physicians have permitted themselves to be parties to this propaganda to have more and more patients go to the hospitals for better care, in preference to receiving home treatment, it may be well to consider some of the facts as they are, and to ask whether or not such propaganda is desirable at this time, and as to what and to where it will lead if continued.

To start the discussion let us look at the existing set-up of general hospitals in states like California, Nevada, and Utah, since the readers of CALIFORNIA AND WESTERN MEDICINE belong to the medical professions of those three states.

Practically no all bed charitable hospitals of any size exist in any of these three states; if the public county or city hospitals, sanctioned by law to care for penniless or indigent sick and injured citizens, are excluded. The number of other hospitals in these states which have any considerable number of free or semi-free beds is also almost nil. To put it frankly, practically all hospitals in these states which offer to care for citizens sent in by physicians in private practice have heavy carrying charges on either their properties or current overhead, more often on both than on one.

With the cost of grounds and buildings we shall not here concern themselves. If the real property, its improvements and its equipment represents fair value for the amount invested therein, and if the buildings, as hospital structures, and the equipment, are well adapted to hospital needs from both the scientific and administrative standpoints, there should be little criticism from lay sources. For in most instances each such institution came into being as a result of the need for an average or a peak hospital load in its respective community.

As regards the administrative overhead of hospitals, there can be wastage in that department, through inefficient or mediocre management or through too heavy salary rolls, just as there can be in a hotel, for instance; because, in one sense, a hospital is little different from a hotel except that its patrons are sick instead of well persons.

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The Cost of Some Professional Services in Hospitals.—This leaves for comment what might be called the special professional services which are part of the hospital itself, namely, the nursing expenses. The cost for professional services of physicians and surgeons is a cost apart from that of hospital care, and does not come under consideration in this argument.

Scientific medicine made comparatively little or slow progress up to a half century ago, when bacteriology gave a new insight concerning infectious diseases and many medical and surgical conditions. Professional nursing, the new handmaiden to this modern scientific medicine, came into existence about that time, and soon gave Americans the "trained or graduate nurse," or latterly, as she is called, the "registered nurse—R. N." Today, when a modern hospital is thought of, there comes at once the visualization of the trained or graduate nurses, who are so intimate a part of its institutional activities.

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Professional Nursing was Sponsored by the Medical Profession.—Members of the medical profession, who laid the foundations for modern trained nursing, who have been the sponsors of trained nurses everywhere, and who have taught the public to accept trained nurses, have a record of service on behalf of nurses sufficient to protect them against assertions of selfish or other undesirable motives if tendencies in modern professional nursing are somewhat critically examined by them. Such survey is desirable if it is possible that a considerable portion of the "high cost of medical care" to which so much publicity is given among the laity, verbally and in print, is found to rest somewhat upon the costs of modern-day hospital nursing.

* * *

How Much Nursing Do Many Hospital Patients Need?—To view the facts as facts, all must acknowledge that many patients in hospitals need only a minimum amount of nursing care, and that if a member of the family could come in and become a part of the hospital system, and give personal and other care to the sick relative, the patient so cared for would go on to good convalescence. For given the case of a hospital patient who has a relative with intelligence, that patient as a rule would prefer the care of such a loved member of the family to that of a stranger even though she be a trained nurse, who at times may be psychologically or otherwise distasteful to the patient.

It is granted by all, that seriously ill patients in hospitals, especially those suffering from surgical conditions, only too often need all the constant and excellent supervision which only the well-trained graduate nurse is as a rule able to give, and such patients may need such care every hour in the twenty-four. Likewise, it has always been agreed that no one nurse could give continuous service without adequate sleep and rest. At least two shifts of nurses are conceded to be necessary, and perhaps three, when seriously ill patients are being cared for.

But it is a very considerable jump from the affirmation that three shifts of trained nurses may be necessary in the care of a limited number of patients to the contention that all hospital patients for whom a certain amount of nursing attendance and supervision is desirable should be provided with three such graduate nurses, each on an eight-hour, sort of labor-union schedule, and each receiving $6 to $10 per day, depending on the case. Such rates would mean $18 to $30 per day for a single day's nursing care.

Some hospitals in California have already accepted such a system and have endeavored to point out that it is an economical system. So it may be, if the patients involved have adequate financial resources, but it is certainly not if the

patients do not possess such means. The great majority of hospital patients lack the possession of such ample financial reserves.

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One Solution of the Fees Involved in an Eight-Hour Nursing Day.—One solution for this new financial problem that has recently demanded the attention of hospital administrators (a considerable number of whom are already almost smothered by their financial overheads) has been the suggestion that if under pressure the eight-hour schedule is forced on hospitals that it be accepted at so much per hour instead of so much per day, with the eight-hour day as the maximum or industrial limit for a calendar day's work.

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Some Other Trends.—More recently it is said that some of the more enthusiastic graduate nurses hold that nurses should charge somewhat as do some surgeons; that is, a nurse who states she is a specialist in pneumonia, for instance, assumes the nursing responsibilities on the basis of a fixed or lump fee for the services to be rendered, say $500 for caring for a pneumonia patient. If such a movement should be promulgated by nurses in general, it would not be long before many of them would have a greater net income than do many physicians, who are on call throughout the day and night, and who are paid when the patients think best.

Along the same line, the old story of the man who rang a physician's door bell at one o'clock in the morning, on a rainy night, to show the physician the way to the home of a sick relative in the country, may be here told. Upon arriving at the house, the man asked the physician the fee for the visit, paying the physician $5 and dismissing him after telling him that the taxi charge would have been twice or thrice the amount. Our nursing aids evidently intend to take no such chances, for we have been told that a recent fee schedule states that calls to service after the p. m. will contain an extra charge for taxi service.

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Important to Study All Factors in Hospital Costs.—It is quite possible that the presentation of some of the facts here made, brief as they necessarily must be because of the limitations of this column, may seem somewhat extreme or biased. Such is not the intention. If these comments, however, serve to stimulate thought on these and related subjects among the component county societies their object will have been achieved.

Excluding a rather small number of physicians and surgeons, it is well established that the great majority of physicians and surgeons are today not receiving fees which, in purchasing power, are as high as those received in the days before the war, that is, in the days before the present "high cost of living."

As has been stated in this column, members of the medical profession owe it to themselves, their profession, and to the public, to be keenly interested in these economic problems. Indifference here may permit cumulative movements that could play havoc with medical standards and practice. Suggestions for betterment of existing conditions are invited by the officers of the California Medical Association.

The Ten Commandments of Cancer.—1. Do not cut across a cancer and leave part behind. The part remaining will grow more rapidly than if you had left it alone, altogether.

2. An operation for cancer is an operation to save life. Cosmetic results are to be considered, but they are not to be weighed against recurrence and death a few years later.

3. Never manipulate a cancer roughly either before or during operation or more often than is necessary to make a diagnosis. To do so is the easiest way to drive cells into the lymph or blood current—hence metastasis.

4. Do not let a woman drag you into her delusion that her early cancer symptoms are due to the menopause. The menopause is a normal physiological state, and if the woman's organs are healthy she will be healthy.

5. Repair every cervix that is eroded, everted, or the seat of a discharge.

6. Do not rule out cancer because the patient is not old. About 10 per cent of cancers occur before thirty-eight.

7. Do not tell your patients they have cancer if you are sure they will follow your advice at once. If they are inclined to delay, tell them frankly what they have and what will be the consequence of delay. If they make their own choice, let it be done with full knowledge of facts and prospects. Tell the relatives or friends in any event.

8. To save your patients from cancer save them from delay. Do not wait for pain and cachexia—the signs of impending death.

9. Do not admit that incurable cancer is unrelievable cancer. Ligation, cautery, palliative removal, electrocoagulation, irradiation, and other proven physical methods may change distress to comfort and add months or years. The patient who appeals to you for relief is the one to be considered—not reputation or "the effect on the community."

10. Be always on the watch for early suspicious symptoms. Be prompt to follow them to a definite diagnosis. Be courageous enough to insist on immediate proper treatment (Weekly Roster and Medical Digest).—*Illinois Medical Journal,* September 1929.

Dangers of Hydrocyanic Gas.—A conference was held during the month between representatives of the Board of State Harbor Commissioners, the State Department of Public Health, and the Industrial Accident Commission, to consider the possible use of hydrocyanic gas for fumigating purposes on the docks. This gas is used to fumigate vessels and cargoes. If cargo is placed on the dock and a tarpaulin is struck by trucks or moved by a passer-by, the escaping gas might kill a number of persons in the vicinity; it was used with deadly effect in the World War. The Board of State Harbor Commissioners has issued an order against the use of the gas on any of the docks.

New dangers will follow the passage of the Economic Poison Act. Strict precautions surround the sale of poisons under one pound in weight. These restrictions are now removed when the purchase exceeds one pound. Hydrocyanic gas, for instance, can be purchased in large quantities. It is used to fumigate trees in orchards. Sometimes it is brought into play to kill unwelcome visitors, not of the human species, in sleeping quarters. Its escape out of bounds will cause havoc some of these days, and public attention needs to be drawn to the wholesale use of poisons in industrial and public activities, to the end that disastrous results may be avoided.—***Reports of California Department of Industrial Relations.***